

APPLICATION # _____

License #

DATE RECEIVED _____
RECEIPT NUMBER _____
AMOUNT PAID _____

CITY OF ROCHESTER
City Clerk's Office
201 4th St SE, Rm 135
Rochester, MN 55902
Phone: (507) 328-2900
Fax: (507) 328-2901

APPLICATION FOR MASSAGE THERAPY BUSINESS LICENSE

Covering the period of _____, 20__ through December 31, 20__

The following items must be completed on the application form. Whoever shall knowingly falsify the answers to the following questions shall be deemed guilty of perjury and shall be punished accordingly.

PLEASE PRINT LEGIBLY.

1. Type of Ownership: / / Sole Proprietor / / Corporation / / Partnership / / LLC
2. Name of Business _____
3. Address of Business _____
4. Federal Tax Number _____ State Tax Number _____
5. Telephone of Business _____
6. If Corporation, State of Incorporation _____
7. If Corporation, list of all persons owning a five percent or more interest in corporation or organization and who are officers of said corporation or organization
8. In answering the following questions, one of the officers of a corporation or partnership shall complete the application for all corporate officers, directors and stockholders or all members of the partnership AND designated on-site manager or Applicant's agent. (attach additional sheets if needed)

Applicant #1

Name _____
(First) (Full Middle) (Last)

Home Address _____

Telephone Number _____ Cell Phone Number _____

E-mail Address _____ Position in Company _____

Social Security Number _____ Driver's License Number _____

Date of Birth _____ Place of Birth _____

Height _____ Weight _____ Eye Color _____

Financial Interest in Company _____

___ YES ___ NO

Has Applicant used /been known by other name than on application. If so, name(s) used and information concerning dates and places where used.

Has applicant ever had any license denied, revoked, or suspended by any local unit of government or any state?
YES _____ NO _____

If Yes, provide the date and location of each occurrence and describe the business activity or occupation of applicant following the license denial, revocation or suspension.

Applicant's Addresses For Previous Five Years (Attach separate sheet if needed)

DATES

ADDRESS

____ YES ____ NO

Has Applicant ever been engaged in the operation of a business providing Massage Therapy. If so, name, place and length of time of involvement in such a business.

Information On Any and All Criminal Conviction(s) of Any State, County or Local Law or Regulation (attach separate sheet if needed)

DATE

OFFENSE

LOCATION

Applicant #2

Name _____

(First) (Full Middle) (Last)

Home Address _____

Telephone Number _____ **Cell Phone Number** _____

E-mail Address _____ **Position in Company** _____

Social Security Number _____ **Driver's License Number** _____

Date of Birth _____ **Place of Birth** _____

Height _____ **Weight** _____ **Eye Color** _____

 YES NO

Has Applicant used /been known by other name than on application. If so, name(s) used and information concerning dates and places where used.

Has applicant ever had any license denied, revoked, or suspended by any local unit of government or any state?
YES _____ NO _____

If Yes, provide the date and location of each occurrence and describe the business activity or occupation of applicant following the license denial, revocation or suspension.

Applicant's Addresses For Previous Five Years (Attach separate sheet if needed)

DATES

ADDRESS

YES NO

Has Applicant ever been engaged in the operation of a business providing Massage Therapy. If so, name, place and length of time of involvement in such a business.

Information On Any and All Criminal Conviction(s) of Any State, County or Local Law or Regulation (attach separate sheet if needed)

DATE

OFFENSE

LOCATION

Applicant #3

Name _____

(First) (Full Middle) (Last)

Home Address _____

Telephone Number _____ Cell Phone Number _____

E-mail Address _____ **Position in Company** _____

Social Security Number _____ **Driver's License Number** _____

Date of Birth _____ **Place of Birth** _____

Height _____ Weight _____ Eye Color _____

 YES NO

Has Applicant used /been known by other name than on application. If so, name(s) used and information concerning dates and places where used.

Has applicant ever had any license denied, revoked, or suspended by any local unit of government or any state?
YES _____ NO _____

If Yes, provide the date and location of each occurrence and describe the business activity or occupation of applicant following the license denial, revocation or suspension.

Applicant's Addresses For Previous Five Years (Attach separate sheet if needed)

<u>DATES</u>	<u>ADDRESS</u>
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____ YES ____ NO

Has Applicant ever been engaged in the operation of a business providing Massage Therapy. If so, name, place and length of time of involvement in such a business.

On-site Manager and/or Agent

Name _____

(First) (Full Middle) (Last)

Home Address _____

Telephone Number _____ **Cell Phone Number** _____

E-mail Address _____ **Position in Company** _____

Social Security Number _____ **Driver's License Number** _____

Date of Birth _____ **Place of Birth** _____

Height_____ **Weight** _____ **Eye Color** _____

____ YES ____ NO

Has Applicant used /been known by other name than on application. If so, name(s) used and information concerning dates and places where used.

Has applicant ever had any license denied, revoked, or suspended by any local unit of government or any state?
YES _____ NO _____

If Yes, provide the date and location of each occurrence and describe the business activity or occupation of applicant following the license denial, revocation or suspension.

Applicant's Addresses For Previous Five Years (Attach separate sheet if needed)

DATESADDRESS

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

___ YES ___ NO

Has Applicant ever been engaged in the operation of a business providing Massage Therapy. If so, name, place and length of time of involvement in such a business.

Information On Any and All Criminal Conviction(s) of Any State, County or Local Law or Regulation (attach separate sheet if needed)

DATEOFFENSELOCATION

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The following items must be answered or accompany the completed application forms.

9.. If Corporation, copy of certification of corporation. If Applicant is foreign corporation, certificate of authority as required by Minnesota Statute 303.06;

10. If Partnership, copy of partnership agreement;

11. Describe the premises to be licensed; _____

12. Are all taxes and special assessments due and owing on the premises on which the Applicant proposes to Operate the Massage Therapy Business are current.

___ YES ___ NO If No, state for which years they are delinquent. _____

13. Proof of General Liability Insurance Coverage as required by the Ordinance (proof can be submitted to the City Clerk prior to license issuance); and

14. Fees: Make Check or Money Order payable to the City of Rochester and return to the Office of the City Clerk, Room 135, 201 4th Street SE, Rochester, Minnesota 55904

(1) Initial Investigation Fee of \$200.00.

(2) License Fee of \$100.00 for an annual Massage Therapy Business License. All license fees shall be paid on a prorated quarterly basis.

15. YES ___ No ___ Has the Business been denied a license under this ordinance in the previous 12 months?

By filling out this application and submitting it to the City of Rochester, I attest that I have read the contents and understand them; I attest that the statements that I have made and the information that I have provided is true and correct and contains a full and true account of the information requested; I execute this statement and application with the knowledge that misrepresentation or failure to reveal information requested may be sufficient cause for denial or revocation of my license/permit and may be punishable by law.

By signing this form I authorize the City, its officers, agents and employees to seek information and conduct an investigation into the truth of the statements set forth in the application and to insure compliance with the applicable provisions of law. My signature will further agree to hold the City of Rochester, its officers, agents or lawfully delegated representative harmless from any action or actions or damages whatsoever or at all, which may result from the background investigation.

I hereby certify, under the penalty of perjury, that the information in this application is true and correct, I understand that providing false information or withholding information, including any criminal records, is grounds for denial or revocation of my permit, and may subject me to criminal prosecution. I do hereby authorize the City of Rochester, its agents and employees to seek verification of the information contained on this application, including a background review. I further understand that I may not conduct the activity applied for until a permit has been granted and that a copy of the City ordinances regulating massage is available to me in the City Clerk's Office.

SIGNATURE OF APPLICANT

TITLE

subscribed and sworn to before me this

_____ day of _____ 20 _____

(NOTARY PUBLIC)

(NOTARY SEAL)

FOR OFFICE USE ONLY

REPORT - POLICE DEPARTMENT:

This is to certify that the City of Rochester Police Department performed a criminal history check on the applicant. The applicant was contacted by a police officer to verify the accuracy of the contents of the application. The Police Investigator's records check revealed the following information:

By: _____

Date: _____

REPORT - FIRE DEPARTMENT

This is to certify that the premises herein described have no outstanding notices or recorded Fire Code Violations:

By: _____

Date: _____

REPORT - PLANNING DEPARTMENT:

This is to certify that the premises have been inspected and they are in compliance with the Rochester Zoning Code:

By: _____

Date: _____

REPORT - BUILDING & SAFETY DEPARTMENT:

This is to certify that the premises herein described have been inspected and that the premises comply with all building and safety codes of the City of Rochester and state of Minnesota with the exception of:

By: _____

Date: _____

REPORT – HEALTH DEPARTMENT:

This is to certify that the premises herein described have been inspected and that the premises comply with all Health Department codes of the City of Rochester and state of Minnesota with the exception of:

By: _____

Date: _____

Date of Council Action: _____

Date License Issued: _____